Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

Thank you for choosing us to provide your eye care.

Name _____

Street _____

City_____ State _____ Zip _____

Spouse (or Parent's Name) _____

Home # ( )_____ Work # ( )_____

Cell # ( )_____ Email_____

Employer (or School) _____

Occupation (or Grade) _____

SS # _____ License # _____

MEDICAL HISTORY

Drug Allergies	No	Yes	Arthritis	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Skin Disorder	No	Yes	Diabetes	No	Yes
Eye Diseases	No	Yes	Heart Disease	No	Yes
Eye Injury	No	Yes	High Blood		
Eye Surgery	No	Yes	Pressure	No	Yes
Lazy Eye	No	Yes	Kidney	No	Yes
Cataracts	No	Yes	Nerves	No	Yes
Glaucoma	No	Yes	Other_____	No	Yes

CURRENT MEDICATIONS (Rx or Over the Counter)

Name of Medication

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently under the care of a physician? No Yes

Name of physician: _____

Dr.'s Phone: _____ Fax: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	RELATIONSHIIP TO YOU
Blindness	❑	❑	_____
Cataract	❑	❑	_____
Crossed Eyes	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Detachment/Disease	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart Disease	❑	❑	_____
High blood Pressure	❑	❑	_____
Kidney Disease	❑	❑	_____
Lupus	❑	❑	_____
Thyroid Disease	❑	❑	_____

KK 9829 Rev. 12/04

Today's Date: _____ Date of Last Exam: _____

Date of Birth: _____ Age: _____ Sex: M____ F ____

Any problems with your present contact lenses or glasses?

_____

Vision Insurance: _____ ID# _____

Insured Member: _____

Medical Insurance: _____ ID# _____

Insured Member: _____

How will you settle your account today?

❑ Check ❑ Cash ❑ Credit Card

Do you participate in a flexible spending account? ❑Yes ❑No

Do you.....

..Work at a computer for long periods? ❑ Yes ❑ No

..Avg. hours per day on computer _____

..Have more than one pair of glasses? ❑ Yes ❑ No

..Want information on thinner, lighter lenses? ❑ Yes ❑ No

..Wear bifocals? ❑ Yes ❑ No

..(If yes, are you bothered by head tilting, restricted areas of vision correction, etc.?) ❑ Yes ❑ No

..Always like to wear your glasses? ❑ Yes ❑ No

..Spend time outdoors? (How much?) ____hrs/week

..Have prescription sunglasses? ❑ Yes ❑ No

..Have problems with glare or reflection, particularly when driving at night? ❑ Yes ❑ No

..Have family members in need of eyecare? ❑ Yes ❑ No

Have you ever worn / are you currently wearing contacts? ❑ Yes ❑ No

What kind?_____Solutions used_____

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in laser refractive surgery? ❑ Yes ❑ No

Are you interested in Cornea Refractive Therapy? ❑ Yes ❑ No

Do you experience any of these symptoms with your eyes?

❑ Burning	❑ Spots	❑ Uncomfortable glasses
❑ Itchiness	❑ Soreness	❑ Sudden loss of vision
❑ Nausea	❑ Flashes of light	❑ Sensitivity to light
❑ Watery eyes	❑ Headaches	❑ Fainting or dizziness
❑ Tearing	❑ Redness	❑ Blurry distance vision
❑ Dryness	❑ Double vision	❑ Blurry near vision
❑ Eye strain		❑ Gritty feeling in eyes
❑ Reading problems		❑ Objects floating in vision
❑ Glare or reflection		❑ Trouble seeing at night
❑ Uncomfortable contact lenses		❑ Trouble reading or learning at work, school,or activity

❑ Other:_____

How did you first hear about our office?

❑ Friend or Relative Who?_____

❑ Another Health Care Practitioner Who?_____

❑ Yellow Pages-----which directory?_____

❑ Drove by / Saw Sign? _____

❑ Civic Group or Community Event Which?_____

❑ Previous Patient Who?_____

❑ Other _____

* *Please turn this form over and complete side two* *